MANUAL TRANSMITTAL
Arkansas Department of Human Services
Division of County Operations

☐ **Policy** ☒ **Form** ☐ **Policy Directive**

Issuance Number FSC 03-02
IMF 03-01

Income Maintenance Forms
Food Stamp Certification **Manual**

Issuance Date 01/01/03

From: Joni Jones
Director

Expiration Date Until Superseded

Subj: ANSWER Forms

Forms to be deleted	Dated	Forms to be added	Dated
None		DCO-136	01/03
None		DCO-215	01/03
None		DCO-216	01/03
None		DCO-217	01/03
None		DCO-237	01/03

List of Forms

DCO-136 *Family Medicaid Assistance-Annual Renewal Notice*
DCO-215 *Request for Assistance*
DCO-216 *Statement of Responsibility for Medicaid, TEA and Food Stamp Applicants*
DCO-217 *Personal Responsibility Agreement*
DCO-237 *Assignment of Rights for TEA and Medicaid Applicants*

These forms are to be used only in counties where ANSWER is operating. Effective 01-02-03 you may order these forms from the warehouse. These forms will be available on DHS GOLD. Counties where ANSWER is being implemented must order adequate supplies of these forms to be received before the implementation date.

CHANGES

The DCO-215 has been revised. The version of the DCO-215 attached to this transmittal is not currently being used in any ANSWER county. An initial supply of the revised DCO-215 will be sent to the ANSWER counties. Until the initial supply is received, counties may continue using the DCO-215. A full supply of the new DCO-215 may be ordered from the warehouse using normal procedures.

Inquiries to: Betty Helmbeck, Food Stamp Section, (501) 682-8284
(*betty.helmbeck@mail.state.ar.us*)

Family Medicaid Assistance
Annual Renewal Notice

If you need this material in a different format, such as large print, please call 1-888-543-7890.

To: _____ **Return To:** _____

_____ _____

_____ _____

Case # _____

If above address has changed, please provide correct address.

ANNUAL RENEWAL INSTRUCTIONS – It is time for the annual renewal of your Family Medicaid eligibility.

Complete each question on this report and return it to your county DHS office by _____. This report will be used to determine your continuing eligibility for Medicaid. **You will not be required to visit your local DHS County Office.**

Please answer all questions as completely and as accurately as possible. If you do not understand a question, please call your caseworker. If you do not have enough space for your answer, attach another sheet of paper.

1 **Household**

Complete if there are any children living in your home that you would like to add to your Medicaid coverage.

Social Security #	Last Name, First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Provide a copy of the child's birth certificate. A copy of the child's social security card would help us to better serve you.
Select a Primary Care Physician for the child you want to add _____
Are there any unpaid medical bills for this child? ❑ Yes ❑ No If yes, for what months: _____

Has anyone moved into your home in the last 12 months? ❑ Yes ❑ No If yes, complete:

Social Security #	Last Name, First Name	Birthdate (MM-DD-YY)	Race	Sex	Relationship to you	U.S. Citizen Yes	No

Has anyone moved out of your home in the last 12 months? ❑ Yes ❑ No If yes, who?

Name	Social Security Number	Date Moved

2 Telephone number where you can be reached, (home)_____ (work or message)_____

3 Is anyone in your home pregnant? ❑ Yes ❑ No If yes, list names _____

4 Would you or anyone in your home like to have Family Planning Services? ❑ Yes ❑ No If yes, list names

_____

5 Child Care (Attach Verification – for example, check stubs or statement from child care provider)
Does any parent pay childcare for any child(ren) receiving Medicaid coverage? ❑ Yes ❑ No
If yes, How much? $ _____ How often? _____.

6 Health Insurance
Does anyone receiving or added to your Medicaid case have health insurance?
❑ Yes ❑ No If yes, please provide:

_____
Individual's Name Insurance Company Date Coverage Began

7 Vehicles (Attach Verification – for example, vehicle title, bill of sale**)**
Did you or anyone buy or sell cars, trucks, boats, trailers or any other vehicle in the past year? ❑ Yes ❑ No If yes, complete the following. Use additional sheets as needed.

Year, Make & Model	Bought	Sold	Current Value	Purchase or Sale Price	Date of Purchase	Date of Sale

8 Resources (Attach Verification – for example, bank statement, insurance policies, burial policies, etc.)
Please list all resources owned and the name of the person who owns.

Resource	Yes	No	Amount	Where	Name of Person(s)
Cash on Hand					
Checking or Saving Account, Money in a Christmas Club or Credit Union					
Life Insurance, Burial Fund/Insurance, Burial Plot/Crypt					
Property other than your home, Mortgages,					
Stocks, Bonds, Trust Fund, C.D., IRA, Promissory Note, Mutual Fund, etc.					

Please list any other resources you have which are not listed above _____

9 Income (Attach Verification – for example, pay stubs, employer statement, award letters, court order, etc.)
Does anyone receive income from the following? Attach additional sheets to explain, if needed.

Source of Income	Y	N	Source	Gross Pay (Before deductions)	How often?	Who receives?
Employment, work, job, farming, self-employment (List all jobs for all individuals included on your Medicaid case)						
Retirement, social security, SSI, veterans benefits						
Child support, alimony, unemployment benefits, worker's compensation, student loans, grants						
Miscellaneous income (part time work, babysitting, rental property, contributions from friends/relatives, roomer or boarders, insurance, etc.)						

Do you expect a change in any of the above? _____ If yes, what and when? _____

PLEASE READ CAREFULLY BEFORE SIGNING THIS FORM

- I understand that if any one receives assistance to which they are not entitled as a result of my withholding information, I will be liable for any overpayment.
- I understand that the information provided on this report may result in loss of my or my children's Medicaid coverage.
- I declare that the information provided is correct.

I understand that by signing this annual report I am subject to penalties for false statements.

Sign Your Name_____ Date _____

Arkansas Department of Human Services

REQUEST FOR ASSISTANCE

IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, CONTACT YOUR LOCAL DHS OFFICE. Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español.

Name	**Social Security Number***	**Date of Birth**	
Mailing Address *(P.O. Box or Street, Apt./Lot #)*	**City**	**State**	**Zip**
Residence Address *(Street, Apt./Lot #)*	**City**	**State**	**Zip**

Home Phone	**Work Phone**	**E-mail Address**	**Race**

WHAT SERVICES ARE YOU REQUESTING? Indicate the services that you want by checking the boxes below.
If you have received assistance in another state, please circle all that apply: Food Stamps TANF Medicaid

❒ **Food Stamps** (*If you believe your household needs food stamp benefits right away, you must complete the questions on the back of this form. The answers to these questions will help us determine if your household may be entitled to receive food stamp benefits within 7 days.)* **Are You Currently Receiving Food Stamps? ❑ Yes ❑ No**

❒ **Transitional Employment Assistance (TEA)** *(This program is for families with children under the age of 18 living in the home.)* **Are You Currently Receiving TEA? ❑ Yes ❑ No**

❒ **Medicaid for** ❒ Me ❒ My Children ❒ Other, explain_____
Are You or Your Children Currently Receiving Medicaid or ARKIDS? ❑ Yes ❑ No
If you checked "Other", where does this person live? ❒ With you ❒ Nursing Home ❒ Other, explain _____

1. Are you or any member of your household pregnant? ❒ YES ❒ NO
2. Do you have a child who is chronically ill? ❒ YES ❒ NO
3. Are you disabled? ❒ YES ❒ NO
4. Are your children covered by a health insurance policy? ❒ YES ❒ NO

HOUSEHOLD MEMBERS *(List all the people who live in your home. Attach sheet listing additional members, if needed)*

Social Security *Number**	***NAME*** ***(First middle initial & last)***	***BIRTHDATE***	***Relationship to you***

* *A social security number is required for all individuals who will receive benefits. The county office worker will help you complete an application for children who do not already have a social security number.*

By my signature I authorize the Department of Human Services (DHS) to get information from other state agencies, banks, and savings and loan institutions, employers, federal agencies, and other sources to prove my statements are true and correct. I understand that when differences are found between what I report and the information provided by the sources listed above, DHS may contact other sources for verification. I further understand that this information may affect my household's eligibility for benefits and the amount of benefits I may receive.

Signature	**Date**
Signature of Witness (*Needed only when applicant signs with an X***)**	

DCO-215 (rev. 01/03)

SCREENING - The answers to the questions below will help us screen your request. Answer each question for yourself and all other household members. Your answers may help us determine whether your household qualifies to receive food stamp benefits within seven days.

1. What is your household's **TOTAL INCOME BEFORE DEDUCTIONS FOR TAXES, INSURANCE, etc?** (*Report money you and other household members receive from work and money received in the form of checks or cash. Report money you and other members of your household have already received and money you expect to receive before the end of the month*.)
   $ _____

2. How much money do you and other household members have in cash, checking accounts, savings accounts, etc.?
   $ _____

3. How much are your household's total shelter costs, including housing and utilities? (*Do not include any past due amounts*.)
   $ _____

4. Is anyone in your household a migrant or a seasonal farm worker? ❒ Yes ❒ No
   (If you answered yes, you must also answer questions A and B below.)

   A. Did your household's income recently stop? ❒ Yes ❒ No
   B. Do you or anyone else in your household expect income from a new source this month? ❒ Yes ❒ No

INCOME AND RESOURCE TYPES - Your caseworker will discuss with you in more detail your family's income and resources. To help in the interview, please circle the type of income and resources you or anyone listed on page one currently have.

Please circle all of the types of income that you or anyone living in your home is receiving.

1. Wages/Salary/Earnings
2. Social Security Benefits (SSA)
3. SSI
4. Child Support
5. Cash Contributions
6. Railroad Retirement
7. Interest/Dividends
8. Military Allotment
9. Veterans Benefits
10. Unemployment Benefits
11. Workers Compensation
12. Work Study
13. College Assistantship
14. Self-employment (including odd jobs, babysitting, yard work)
15. Rental
16. VISTA
17. WIA Training Allowance
18. Sick Pay/Maternity Benefits
19. Retirement/Pension/Annuity
20. Other _____
    _____

Please circle all of the types of resources that belong to you or anyone living in your home.

1. Checking Account
2. Savings Account
3. Certificate of Deposit (CD)
4. Christmas Club Account
5. Boats/ Motors/ Trailers
6. Campers
7. RV (Motor Home)
8. Car/Truck/Van
9. Motorcycle
10. ATV
11. Golf cart/ Go-cart/ Moped
12. IRA/ KEOGH/ 401K
13. Mutual Funds
14. Trust Funds
15. Stocks/Bonds
16. Land/ Buildings/Houses - (other than your home)
17. Mobile Home
18. Burial Plots
19. Revocable Prepaid Burial Plan
20. Other _____

Have you sold or given away any of the above resources in the past 3 months? ❑ Yes ❑ No
Have you sold or given away any of the above resources in the past 36 months? ❑ Yes ❑ No

EXPENSES
Please circle each type of expense that someone in your home pays.

1. Rent
2. Mortgage Payment
3. Taxes on real property
4. Insurance on real property
5. Utilities
6. Telephone
7. Baby sitter or day care
8. Medical costs
9. Child support

STUDENTS - Is anyone in your home currently enrolled in a college, vocational school, technical school or any other training program beyond high school? **YES ❒ NO ❒**

AUTHORIZED REPRESENTATIVE - If you want to authorize someone to represent you, please complete the following information. If you name an authorized representative, this person will be able to take your place at the interview and talk to the DHS county worker on your behalf.

Name_____ Telephone Number _____

Mailing Address _____

City _____ State _____ Zip _____

Notice to Applicants

- *In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.*

  To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

- *Providing a social security number and/or information about citizenship or immigration status is voluntary. However, anyone who fails or refuses to provide any of this information will not be eligible to receive food stamp benefits. Other household members who do provide this information may participate in the Food Stamp Program if the household is found to be eligible.*

- *Participation in the Food Stamp Program and the Medicaid Program is not time-limited. You can continue to receive Food Stamp and/or Medicaid benefits as long as you are eligible under Program rules. This is true even if someone in your home receives TEA cash assistance. If someone in your home does receive TEA cash assistance, participation in the Food Stamp Program or the Medicaid Program will not count against their TEA time limits.*

Providing Information

You must declare social security numbers for everyone who will receive benefits. Bringing items such as your most recent paycheck stubs, award letters, and bank statements to your interview may speed up the application process. During the interview, the DHS worker will tell you if you must provide any additional information.

County Use Only County _____ Date Received _____

Categories 1)_____ 2)_____ 3)_____

EXPEDITED (Food Stamp Application) ❒ YES ❒ NO Screener_____ LD Date _____

DHS County Office Mailing Addresses

County	*Address*	*City*	*Zip*	*County*	*Address*	*City*	*Zip*	*County*	*Address*	*City*	*Zip*
Arkansas	100 Court Square	DeWitt	72042	Grant	PO Box 158	Sheridan	72150	Ouachita	PO Box 718	Camden	71711
Arkansas	PO Box 1008	Stuttgart	72160	Greene	PO Box 839	Paragould	72451	Perry	213 Houston Ave.	Perryville	72126
Ashley	PO Box 190	Hamburg	71646	Hempstead	116 N. Laurel	Hope	71802	Phillips	PO Box 277	Helena	72342
Baxter	PO Box 408	Mt. Home	72654	Hot Spring	PO Box 813	Malvern	72104	Pike	PO Box 200	Murfreesboro	71958
Benton	900 SE 13th Court	Bentonville	72712	Howard	PO Box 1740	Nashville	71852	Poinsett	PO Box 526	Harrisburg	72432
Boone	PO Box 1096	Harrison	72601	Independence	100 Weaver Ave	Batesville	72501	Polk	606 Pine St.	Mena	71953
Bradley	PO Box 509	Warren	71671	Izard	PO Box 65	Melbourne	72556	Pope	701 N. Denver	Russellville	72801
Calhoun	PO Box 1068	Hampton	71744	Jackson	PO Box 610	Newport	72112	Prarie	PO Box 356	DeValls Bluff	72041
Carroll	PO Box 425	Berryville	72616	Jefferson	PO Box 5670	Pine Bluff	71611	Pulaski East	PO Box 8083	Little Rock	72203
Chicot	PO Box 71	Lake Village	71653	Johnson	PO Box 1636	Clarksville	72830	Pulaski Jax.	PO Box 626	Jacksonville	72078
Clark	PO Box 968	Arkadelphia	71923	Lafayette	2612 Spruce St.	Lewisville	71845	Pulaski No.	PO Box 5791	N. Little Rock	72119
Clay-1	PO Box 366	Piggott	72454	Lawrence	PO Box 69	WalnutRidge	72476	Pulaski So.	PO Box 2620	Little Rock	72203
Clay-2	1007 Ada St.	Corning	72422	Lee	PO Box 309	Marianna	72360	Puluaski SW	PO Box 8916	Little Rock	72219
Cleburne	PO Box 1140	Heber Springs.	72543	Lincoln	101 W. Wiley St.	Star City	71667	Randolph	1408 Pace Rd.	Pocahontas	72455
Cleveland	PO Box 465	Rison	71665	Little River	90 Waddell St.	Ashdown	71822	Saline	PO Box 608	Benton	72018
Columbia	PO Box 1109	Magnolia	71754	Logan-1	#17 W. McKeen	Paris	72855	Scott	PO Box 840	Waldron	72958
Conway	PO Box 228	Morrilton	72110	Logan-2	398 E. 2nd St.	Booneville	72927	Searcy	350 School	Marshall	72650
Craighead	2920 McClellan Dr.	Jonesboro	72401	Lonoke	PO Box 260	Lonoke	72086	Sebastian	616 Garrison #231	Ft. Smith	72901
Crawford	704 Cloverleaf Crle	Van Buren	72956	Madison	PO Box 128	Huntsville	72740	Sevier	108 Tn N, ProBdgA	DeQueen	71832
Crittenden	401 S. Airport Rd.	W. Memphis	72301	Marion	PO Box 447	Yellville	72687	Sharp	PO Box 159	Ash Flat	72513
Cross	PO Box 572	Wynne	72396	Miller	3809 Airport Plz.	Texarkana	71854	St Francis	PO Box 899	Forrest City	72336
Dallas	1202 W. 3rd St.	Fordyce	71742	Mississippi 1	1104 Byrum Rd.	Blytheville	72315	Stone	HC 71 Box 180	Mountain View	72560
Desha	PO Box 1009	McGehee	71654	Mississippi 2	437 S Country Club	Osceola	72370	Union	123 W. 18th St.	El Dorado	71730
Drew	PO Box 1350	Monticello	71657	Monroe-1	PO Box 354	Clarendon	72029	Van Buren	362 Ingram Street	Clinton	72031
Faulkner	PO Box 310	Conway	72033	Monroe-2	301½ N New Orlean	Brinkley	72021	Washington	4044 Frontage	Fayetteville	72703
Franklin	800 W.Commercial	Ozark	72949	Montgomery	PO Box 445	Mt. Ida	71957	White	608 Rodgers Drive	Searcy	72143
Fulton	PO Box 650	Salem	72576	Nevada	PO Box 292	Prescott	71857	Woodruff	PO Box 493	Augusta	72006
Garland	115 Market St.	Hot Springs	71901	Newton	PO Box 452	Jasper	72641	Yell	PO Box 277	Danville	72833

Fold in half, staple or tape ends together, and mail to your local DHS County Office

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Return Address

_____

_____

_____

Place Stamp Here

Mail or bring to your local DHS county office

STATE OF ARKANSAS

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF COUNTY OPERATIONS

Statement of Responsibility
for
Medicaid, TEA and Food Stamp Applicants

Applicant _____ SSN _____ County _____

FOOD STAMP PROGRAM - INTENTIONAL PROGRAM VIOLATIONS

Any member of your household who intentionally breaks any of the following rules will not be able to get food stamp benefits for one year. The second time a household member intentionally breaks one of these rules, he or she will not be able to get food stamp benefits for two years. The third time a household member intentionally breaks one of these rules, he or she will never again be allowed to get food stamp benefits.

- **DO NOT GIVE FALSE INFORMATION OR WITHHOLD INFORMATION IN ORDER TO GET OR TO CONTINUE TO GET FOOD STAMP BENEFITS.**
- **DO NOT ALTER ANY AUTHORIZATION DOCUMENT TO GET FOOD STAMP BENEFITS YOU ARE NOT ELIGIBLE TO RECEIVE.**
- **DO NOT USE FOOD STAMP BENEFITS TO BUY NON-FOOD ITEMS LIKE ALCOHOLIC DRINKS, TOBACCO, OR PERSONAL GROOMING ITEMS.**
- **DO NOT TRADE OR SELL FOOD STAMP BENEFITS OR ALLOW UNAUTHORIZED USE OF ELECTRONIC BENEFITS TRANSFER (EBT) CARDS.**
- **DO NOT USE SOMEONE ELSE'S EBT CARD FOR YOUR HOUSEHOLD'S BENEFIT.**

A court of law can ban anyone who intentionally breaks Food Stamp Program rules from getting food stamps for an additional 18 months. A court can also impose fines of up to $250,000 or send the violator to jail for up to 20 years or both.

TEA PROGRAM - INTENTIONAL PROGRAM VIOLATIONS

Intentional Program Violation – This is any false or misleading statement, misrepresentation, concealment, or withholding of facts by an individual for the purpose of establishing or maintaining the family's eligibility for TEA or for the purpose of increasing or preventing a decrease in the amount of the TEA grant. The family of any individual who pleads guilty or nolo contendere to, or is found guilty of, an intentional program violation in the TEA program will be ineligible for further participation in the program for one year for the first offense, for two years for the second offense and permanently for any subsequent offense. The family will continue to be ineligible for TEA until the resulting overpayment is repaid to the State.

Fraudulent Misrepresentation of Residence – This is a fraudulent statement or misrepresentation of residence in order to receive assistance simultaneously from two or more states. The family of an individual who is convicted in a federal or state court of a fraudulent misrepresentation of residence will be ineligible to receive TEA for a minimum of ten years beginning with the date of conviction. The family will continue to be ineligible for TEA until the resulting overpayment is repaid to the State.

YOU MUST SIGN THE BACK OF THIS PAGE.

OTHER DISQUALIFICATIONS

Individuals found to have made a fraudulent statement or representation about their identity or residence in order to get food stamp benefits in two locations during the same month will be barred from getting food stamp benefits for ten years.

The Following Individuals are Permanently Banned From Participating in the Food Stamp Program

- Violators found guilty in a court of law of buying or selling fire arms, ammunition, explosives, or controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for food stamp benefits.
- Violators convicted in a court of law of trafficking food stamp benefits in excess of $500.

The Following Individuals are Ineligible to Participate in Either the Food Stamp or the Tea Program

- Any individual currently classified as a fugitive felon, parole violator or probation violator.
- Any individual who was found guilty of or who pled guilty or nolo contendere (no contest) to any state or federal offense classified as a felony by the law or jurisdiction involved which has as an element of the offense the distribution or manufacture of a controlled substance.

READ THE FOLLOWING INFORMATION CAREFULLY

- I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.
- I understand that if I ask for help in getting the information I need to establish my eligibility, the county office worker will provide this help.
- I authorize DHS to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand that no person may be denied Medicaid, Food Stamp, or TEA benefits on the grounds of race, color, sex, age, handicap, religion, national origin, or political belief.
- I understand that I may request a hearing from DHS if a decision is not made on my case within the proper limit or if I disagree with the decision.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal administrative or judicial proceeding.
- I understand that TEA cash assistance will be limited to twenty-four months of my lifetime.
- If I am a TEA or Medicaid recipient, I agree to notify the DHS County Office within 10 days if: I or any of my dependents cease to live in my home, if I move, if I become employed or my earnings change, or if any other changes occur in my circumstances.
- If I receive Food Stamp benefits, I understand that I may be required to submit a quarterly report. If I am not required to submit a quarterly report, I agree to report changes in my circumstances within 10 days.
- I understand the questions I have been asked. I understand the penalties for hiding information or giving false information.
- I understand that if I receive benefits for which I am not eligible because I withheld information or deliberately gave false information, any assistance I receive in the future may be reduced to recover this overpayment and I may be subject to prosecution for fraud and fined and/or imprisoned.
- I understand that I must be employed to receive TEA Extended Support Service (ESS) child care assistance. I understand that if I continue to receive ESS child care assistance while I am not employed, I will be required to repay DHS all such assistance received and may be subject to prosecution for fraud and fined and/or imprisoned.

_____ _____

Signature **Date**

Arkansas Department of Human Services
Division of County Operations
Personal Responsibility Agreement

I understand public assistance is temporary as I seek to become self-supportive and economically independent. I understand that it is my responsibility to find and keep a job and to secure all other potential sources of income for the support of my dependent and myself.

In return for public assistance, I agree to be held responsible for:

1. Looking for employment or following up on job referrals required by my caseworker before, during and after approval of my application for assistance.

2. Cooperating with my caseworker in developing and following my Employment Plan. DHS has informed me that the supportive services described in the attached information will be available to me as needed to comply with my Employment Plan.

3. Accepting full or part-time employment that may be offered.

4. Not voluntarily terminating employment.

5. Ensuring that my children receive their age appropriate childhood immunizations. (I understand that I will receive guidance from my caseworker on how to achieve this without cost to myself.)

6. Ensuring that my school age children attend school.

7. If I am an unmarried minor parent, I will reside in the household of a parent, legal guardian, other adult relative, or in an approved adult-supervised living arrangement unless my caseworker approves other living arrangements. I understand that I should tell my caseworker right away if circumstances occur that require an alternative living arrangement.

8. Cooperating with the Office of Child Support Enforcement in seeking child support payments and/or establishing paternity.

I understand that in some circumstances the agency may determine that I had good cause for not complying with the above requirement and in certain unique circumstances I may be granted an extension or exemption of a specific program requirement.

Parent/Caretaker Relative Signature	Date
Parent/Caretaker Relative Signature	Date
Minor Parent Relative Signature (if appropriate)	Date
Case Worker's Signature	Date

ASSIGNMENT OF RIGHTS
FOR TEA AND MEDICAID APPLICANTS

ASSIGNMENT OF MEDICAL SUPPORT (MEDICAID ONLY)

I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

CHILD SUPPORT ENFORCEMENT REQUIREMENTS

TRANSITIONAL EMPLOYMENT ASSISTANCE (TEA) - I understand that if I accept TEA cash assistance, by state law, I will have **assigned all rights, title, and interest in any support** that I have in my own behalf or in behalf of any other person for whom I am receiving TEA. I understand that all support payments including those received by me directly from the absent parent, are to be paid to the Office of Child Support Enforcement. I understand that this **assignment** ends when I no longer receive TEA except as to any unpaid support obligation that has accrued at the time my TEA case is closed. I also understand that as a condition of eligibility for TEA, I must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.

MEDICAID - As a condition of eligibility for Medicaid, adult caretaker relatives receiving Medicaid for themselves as well as for children, must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE receives a written notice from the caretaker relative declining those services. If the adult caretaker relative is not receiving Medicaid, cooperation with OCSE is strictly voluntary.

_____ _____

Signature **Date**

IMPORTANT ESTATE RECOVERY NOTICE:

If you receive Medicaid in a nursing facility, ICF/MR facility, or under a home and community based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate after your death. Your estate is the property you own at the time of your death. DHS will not make a claim against your estate while you are living. DHS will not make a claim against your estate after your death if your spouse is still living, or if you have dependent children under age 21 or blind or disabled children. DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost effective to DHS or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.

I have read the Assignment of Medical Support on page 1 and the above notice on Estate Recovery.

_____ _____

Signature **Date**